DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) NAME OF PROVIDER OR SUPPLIER: DR. ARTHUR CLIFTON MCKINLEY CENTER		· · · · · · · · · · · · · · · · · · ·		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING: CITY, STATE, ZIP CODE: BROOKE DRIVE E, PA 15825		(X3) DATE SURVEY COMPLETED: 04/19/2023	
STATE LICENSE NUMBER: 421402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0000	Based on a Follow-up Survey completed on April 19, 2023, it was determined that Dr. Arthur Clifton McKinley Center corrected the deficiencies cited during the surveys ending January 18, 2023, and February 28, 2023, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.			F 0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable

TITLE:

(X6) DATE:

within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

DR. ARTHUR CLIFTON MCKINLEY HEALTH CENTER

STATE LICENSE NUMBER: 421402 SURVEY EXIT DATE: 04/19/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY